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The Political Economy of Global Responses to COVID-19

Edited by Alan W. Cafruny · Leila Simona Talani

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome caused by the Human Immunodeficiency Virus (HIV)
AMC	COVAX Advance Market Commitments
APAs	Advance Purchase Agreements
APIs	Active Pharmaceutical Ingredients
APP	Asset Purchase Programme
CAA	Citizenship Amendment Act
CCP	Chinese Communist Party
ACDC	Africa Centres for Disease Control and Prevention
CDC	Centers for Disease Control and Prevention
CDC	Communicable Diseases Center
CDC	U.S. Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CJRS	Coronavirus Job Retention Scheme
COINEX	The SAARC COVID-19 Information Exchange Platform
COVAX	COVID-19 Vaccines Global Access
DHSSPS	Department of Health, Social Services and Public Safety
DWSR	Dollar-Wall Street Regime
EaP	Eastern Partnership
EBRD	European Bank for Reconstruction and Development
ECB	European Central Bank
EFSI	European Fund for Strategic Investments

EIB	European Investment Bank
EIF	European Investment Fund
EMA	European Medicines Agency
Ems	European Member States
ENP	European Neighbourhood Policy
EU	European Union
FHM	The Public Health Agency
FPA	Foreign Policy Analysis
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFC	Global Financial Crisis
GP	General Practitioner
ICMS	Imposto sobre Circulação de Mercadorias e Prestação de Serviços de Transporte Inter-estadual e Intermunicipal e de Comunicação
IDA	International Dispensary Association
IHU Méditerranée Infection	Institut Hospitalo-Universitaire Méditerranée Infection
IMF	International Monetary Fund
IOs	International Organisations
IP	Intellectual Property
IS	International System
KSMs	Key Starting Materials
LMICs	Low and Middle Income Countries
LQFEx	Laboratório Químico e Farmacêutico do Exército
LTROs	Longer-Term Refinancing Operations
MEA	Ministry of External Affairs
MFF	Multiannual Financial Framework
MoHFW	Ministry of Health and Family Welfare
MOU	Memoranda of Understanding
MP	Member of Parliament
mRNA	Messenger RNA
NAFTA	North American Free Trade Agreement
NAM	Non-Aligned Movement
NCMS	New Cooperative Medical Scheme
NGOs	Non-Governmental Organisations
NHC	National Health Commission
NHS	National Health Service
NIHP	National Institute for Health Protection
NRC	National Register of Citizens
NRRP	National Recovery and Resilience Plan
NSC	National Security Council

OECD	Organisation for Economic Cooperation & Development
PAC	House of Commons Public Accounts Committee
PCR	Polymerase Chain Reaction
PEPP	Pandemic Emergency Purchase Programme
PPE	Personal Protective Equipment
PPP	Public–Private Partnerships
ProMED	Program for Monitoring Emerging Diseases
QE	Quantitative Easing
QUAD	Quadrilateral Security Initiative
R&D	Research & Development
RDIF	Russian Direct Investment Fund
RRF	The Recovery and Resilience Facility
RRPs	Recovery and Resilience Programmes
S&T	Science and Technology
SAARC	South Asian Association for Regional Cooperation
SALAR	The Swedish Association of Local Authorities and Regions
SARS-CoV-2	Virus causing COVID-19 pandemic
SDMC	SAARC Disaster Management Centre
Sin-Med RJ	Sindicato dos Médicos do Rio de Janeiro
SURE	Support Unemployment Risks in Emergency
SWIFT	Society for Worldwide Interbank Financial Telecommunication (SWIFT)
TLTROs	Targeted Long-Term Refinancing Operations
TUI	Touristik Union International
UEBMI	Urban Employee Basic Medical Insurance
UKHSA	UK Health Security Agency
UNECA	U.N. Economic Commission for Africa
UNICEF	United Nations Children's Fund
URBMI	Urban Resident Basic Medical Insurance
USA	United States of America
USAID	US Agency for International Development
VOCs	Variants of Concern
WHO	World Health Organization
WMHC	Wuhan Municipal Health Commission
WTO	World Trade Organization

CHAPTER 1

Introduction: The Political Economy of the COVID-19 Crisis—Neoliberalism, Populism, and Autocracy

Alan W. Cafruny and Leila Simona Talani

The COVID-19 crisis that erupted in Wuhan, China at the end of 2019 caused a massive loss of human life and triggered a global economic crisis comparable to that of the Great Depression of 1929. By mid-November 2022, just two years and eight months after Chinese public health officials identified the genome of the virus the World Health Organization recorded more than 633 million confirmed cases of COVID-19 and more than 6.5 million deaths worldwide (W.H.O. 2022). The number

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of "excess deaths," arguably a more accurate measure of the lethal consequences of the virus, may have reached three times that number (Economist 2022). In September 2022 a Commission assembled by the Lancet comprising 11 global task forces, 100 consultants, and 28 leading experts in public policy and epidemiology declared that "The staggering death toll is both a profound tragedy and a massive global failure at multiple levels" (Lancet Commission 2022).

The development of vaccines in early 2021 followed by the provision of anti-viral treatments a year later helped to reduce the death toll significantly, especially in high-income countries, notwithstanding persistent vaccine resistance. It is possible that COVID-19 will soon transition from a *pandemic*, defined as "an epidemic of disease, or other health condition that occurs over a widespread area (multiple countries or continents) and usually affects a sizable part of the population" to an *epidemic*, meaning regular occurrences in specific areas and following specified patterns (Last 2001). On September 18, 2022 U.S. President Joe Biden proclaimed that "The pandemic is over…no one's wearing masks. Everybody seems to be in pretty good shape…" (NPR 2022). Throughout the world national health authorities, with the exception of China, abandoned quarantines, compulsory testing, and masking mandates.

Yet, while the COVID-19 virus is widely expected eventually to become an epidemic, this optimistic scenario may be premature. The dissemination of vaccines to the global south has been very slow, reaching less than one in seven by September 2022. It is possible that novel BA.4 and BA.5 Omicron variants will overwhelm the ability of existing vaccines to contain the disease and prove resistant to anti-viral treatments. Further mutations of the virus could even cause more severe illness. At the same time, "Long Covid" resulting in a variety of symptoms including fatigue, cognition, depression, and anxiety afflicts large numbers of people. For example, by mid-September 2022 between 2 and 4 million had left the U.S. workforce as a result of Long Covid (Bach 2022). Further surprises for humanity may be in store.

Despite its global reach, the pandemic has had a varied impact on nations both in terms of cases and deaths, and also economic impact. The adoption of a "zero covid" strategy enabled China's leaders to limit the number of cases and deaths even as the country maintained impressive growth rates in 2021 (8.1%) and 2022 (projected 5.1%) notwithstanding strict and contentious lockdowns. Other Asian countries including South Korea, Japan, Hong Kong, New Zealand, Australia, Viet

Nam, and Taiwan also managed to reduce significantly the number of COVID-19 cases. Western Pacific countries, including East Asia, recorded approximately 300 deaths per million as a result of "relatively successful suppression strategies" (Lancet Commission 2022).

By contrast, most Western countries struggled to develop and sustain effective policies for dealing with the pandemic, despite scoring the highest rankings in the 2019 Global Health Security Index (Lancet 2022). They tended to alternate between periods in which they followed the advice of the scientific communities, and periods during which economic concerns prevailed and ruled out the imposition of rigorous approaches. At the same time, scientific communities themselves were often frequently divided and politicized. This was the case especially in the United Kingdom and the United States, both of which suffered disproportionately severe human and economic consequences from the pandemic by comparison to most other high-income countries. Thus, Western countries experienced cumulative deaths of approximately 4000 per million, "the highest of all WHO regions" (Lancet Commission 2002), illustrating that the tremendous variation in death tolls was not a function of wealth.

The COVID-19 pandemic unleashed a massive global economic crisis that would become exacerbated by the war in Ukraine. As a result of death and lockdown global labor markets imploded. Led by the United States, governments responded with fiscal efforts, reaching $8 trillion by April 2020 and $14 trillion by January 2021 (Tooze 2021: 131). Led by the U.S. Federal Reserve, central banks pumped trillions of dollars into the financial system, triggering massive asset speculation resulting in seemingly intractable, 40-year-high inflation rates that threatened to push the world into deflation, with massive negative consequences for developing countries. Thus, the economic effects of the pandemic exposed all of the problems and contradictions of the world economy that had not fully recovered from the global financial crisis of 2008–2010.

This book seeks to identify the reasons why some countries were more efficient and effective than others in responding to the pandemic, and why the global community failed to coalesce. What are the political determinants of the different state responses to the pandemic? Why was scientific advice rejected or ignored in many countries? What has been the role, respectively, of neoliberalism, populism, and authoritarianism in the making of COVID-19 policy? What role has each of these factors played in the uneven and clearly inadequate global response to the pandemic? Of

course, analyses of individual state responses—and policy recommendations deriving from them—must be advanced with caution if only because the virus has not yet been contained.

The book is accordingly divided into four parts:

- Part I: Neoliberal states: The United Kingdom, the United States, and Greece
- Part II: Populist states: Brazil, India, and Italy
- Part III: Authoritarian states: China and Russia
- Part IV: Global Inequality

In an effort to identify the motivations for the inability of some states to tackle the pandemic properly, some of the literature suggests that populism is at the roots of the failure of international cooperation nowadays. Frieden (2021: 1),[1] for example, observes that the post-World War Two had been characterized by a notable tendency toward more global cooperation. The global financial crisis of 2008–2010 triggered significant global cooperation within the G-20, led by the combined efforts of the United States and China. These forms of cooperation have clearly gone missing in the context of the pandemic where lack of cooperation would not only be limited to the field of economics but also health and the management of the Covid-19 Pandemic: (e.g. Tooze 2021; Kahl and Wright 2021).

The authors of this volume link the different state responses to the pandemic, from its inception to the start of the vaccination campaign, to the political regimes prevailing in each of them. In particular, the present volume focuses on a distinction between the responses of neoliberal regimes, populist regimes, and authoritarian ones.

The chapters in Part I explore the impact of neoliberalism in both its economic and cultural manifestations. Alan Cafruny and Tara McCormack show that policies in both the United States and the United Kingdom were inflected by neoliberalism characterized above all by the privatization of public health. The neoliberal context ultimately underwrote an inadequate and extremely limited response in which populist rhetoric provided a supporting—albeit not primarily causal—role. Vassillis

[1] Frieden, Jeffry. (2021). International Cooperation in the Age of Populism. https://doi.org/10.1007/978-3-030-53265-9_21.

Fouskas shows that the Greek response was tragically impeded by the legacy of years of neoliberal austerity, further complicated by the Greek government's geopolitical ambitions.

As Part II shows populist governments did, however, play a very strong role in the response to the containment, as indicated by Jorg Nowak's analysis of Brazil, Leila Simona Talani's exploration of the Italian response, and Uma Purushothaman and John Moolakkattu's analysis of India. Populist leaders "have tended to put in place fewer interventionist public health policies and strategies (for example by responsibilising individual citizens rather than mandating a government response), and were slower to implement lockdowns at local or national levels, than non-populist ones…in some cases have dismantled the very institutions designed to safeguard against major threats to public health" (Mannion and Speed 2021: 177) The political culture associated with right-wing populism clearly played an important role in reinforcing institutional and governmental dysfunctions in both Brazil and India, characterized in the former by corruption and disorganization and in the latter by repression. By contrast, as Leila Talani shows in her analysis of the response of the Italian 5 Star government, populism has not always proved an impediment to the application of science and, hence, containment.

Part III contrasts the distinctive responses of two authoritarian states: China and Russia. Although the virus first appeared in China, the adoption of a "zero covid" strategy enabled China's leaders greatly to limit the number of cases and deaths even as the country managed to achieve positive growth rates in 2020 and 2021. However, as Alexsia Chan shows, the uncertainties resulting from the emergence of the Omicron variant suggest that even China may not be able to maintain its "zero covid" strategy indefinitely. Moreover, if authoritarianism enabled effective state response in some respects, in other respects it impeded effective measures and attempts to legitimize policies. By contrast, as Serena Giusti and Eleonara Tafuro show, notwithstanding significant authoritarian characteristics, the Russian state has been unable to impose its control over the pandemic either in the form of social control or vaccine uptake.

Finally, in Part IV our authors turn our attention to the global sphere. The pandemic has greatly accelerated the pace of geopolitical and geoeconomic transformation. As Adam Tooze has noted, for the first time since World War II—and in contrast to the experience of the global financial crisis of 2008—U.S. leadership has been absent. Moreover, while the former crisis was characterized by Sino-American

cooperation, the pandemic has witnessed deepening hostility. Even as the concentration of COVID-19 infections mimic maps of manufacturing, transportation, and storage hubs community lockdowns and individual measures cannot in themselves contain a virus in the absence of global cooperation. Yet, as Robert Fatton's analysis of Africa's predicament and Matt Sparke's and Owain David Williams's exploration of the implications of neoliberal globalized governance shows, in the context of globally integrated production and transportation, competing nation states have been demonstrably unable to transcend narrow conceptions of national interest. Yet, ironically Africa's woes have not resulted primarily from poverty or limited state capacity, but rather the impact of Northern lockdowns. Finally, Mariangela Veikou explores the impact of precarity on discourse on public health.

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PART I

Neo-Liberal States

CHAPTER 2

Populism, Neoliberalism, and the Pandemic: The Tragedy of U.S. Policy

Alan Cafruny

Introduction

The United States overall wealth, leadership in absolute and per capita health care spending, and unrivaled scientific and epidemiological expertise provided the necessary material conditions for the effective containment of the Covid-19 pandemic. Widely regarded as the leading global agency for combating infectious diseases, the Centers for Disease Control (CDC) played a leading role in the global response to Ebola, Zika, and H1N1. The Bush (2001–2009) and Obama (2009–2017) administrations prioritized the rapid response to future pandemics. In 2019 a 324-page comparative analysis by Johns Hopkins University concluded that the United States led the world in pandemic preparation (GHS Index, 2019; Jones and Hameiri, 2021). The United States hosts leading

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global biotechnology firms with the capacity to develop and mass produce vaccines.

Yet, the United States management of the pandemic has been substantially worse than that of any other wealthy industrialized country. The first case of Covid-19 in the United States was confirmed on January 20, 2020. By April the United States had emerged as the epicenter of the global pandemic in terms of absolute deaths, and surrendered this position only a year later when the mass production and distribution of vaccines and the growth of natural immunity began to slow the spread of the disease. Between January 3, 2020 and November 18, 2022 the United States experienced more than 96 million confirmed cases of Covid and more than 1.1 million Americans died. The United States has 4.25% of the world's population but accounted for approximately 16% of global deaths although based on "excess deaths" the death count may have exceeded 1.2 million (Donavan, 2022). While Covid-19 data are notoriously inexact, by June 2022 the United States ranked 18th worldwide in per capita deaths, and was by far the leader among OECD countries, experiencing a death rate approximately 20% greater than Belgium, the United Kingdom, and Italy; and almost double that of Germany.[1] In September 2022 the U.S. labor force had declined by 500,000 as a result of the disease (NYT, 2022). Throughout 2020 and 2021 life expectancy plummeted to 76.6 years, lowest in 25 years and in sharp contrast to the experience of all other wealthy countries (Stein, 2022). In assessing the first year of U.S. policy the influential *British Medical Journal* cited "the lack of political attention to social determinants and inequities that exacerbate the pandemic," condemning the overall response as "social murder (BMJ, 2021)."

This chapter demonstrates the close connection between the agenda of right-wing populism and dysfunctional policies toward testing, provision of medical equipment, lockdowns, and vaccines. At the same time, a comprehensive explanation for the U.S. policy response and its transformative social impact must also account for the underlying neoliberal "pre-existing condition" and resultant serious inadequacies in public health in which the virus appeared. Fiscal and monetary policies designed

[1] By comparison, the influenza pandemics of 1957 and 1968 caused, respectively, 100,000 and 110,000 deaths. In 1952 polio killed 3145 Americans and infected 57,879, although leaving many with some form of paralysis. The "Asian Flu" of 1,918,019 claimed the lives of 675,000 Americans within an overall population of 1.3 million.

ostensibly to cushion society from sickness and recession within a diminished public health environment also served to deepen inequality and impose a disproportionate share of the burden of adjustment on the poorest Americans.

Governance Crisis and the Politicization of the Pandemic

The U.S. experience accords with an extensive literature showing that right-wing populism has generally led to a distinctive and counterproductive response to the pandemic (Kavaki, 2020; Mannion and Speed, 2021; Rambousek, 2021; Ortega and Orsini, 2020).[2] Right-wing populist leaders such as Donald Trump, Boris Johnson (United Kingdom), Jair Bolsonaro (Brazil), and Narendra Modi (India) "have tended to put in place fewer interventionist public health policies and strategies (for example by responsibilising individual citizens rather than mandating a government response), and were slower to implement lockdowns at local or national levels, than non-populist ones…in some cases have dismantled the very institutions designed to safeguard against major threats to public health." (Mannion and Speed, 2021, p. 177) Appealing to their anti-elitist base most have ignored or actively contradicted scientific advice, most notably with respect to lockdowns, the wearing of masks, and vaccinations. They have explicitly or implicitly favored strategies of "herd immunity."

The Trump administration's record corroborates this conclusion. The political culture associated with right-wing populism clearly played an important role in reinforcing institutional and governmental dysfunctions. Amid widespread predictions of future pandemics based on the experience of SARS, H1N1, and Ebola, in 2015 the Obama administration established the Global Health Security and Biodefense unit with responsibility for pandemic preparedness within the National Security Council (NSC) (Dozier and Bergengruen, 2020).[3] Building on the work of this

[2] Talani's analysis of the Italian case in this volume represents an interesting and important exception.

[3] These pandemics were qualitatively different than SARS-Covid-19. They did not expose the profound deficiencies in the U.S. health care system that had been arising since the 1970s. Severe Acute Respiratory Syndrome (2002–2004) led to 8092 global cases, with 8 U.S. cases and no deaths. The H1N1 flu virus (2009) infected 24% of the

unit, in January 2017 the outgoing Obama Administration hosted 30 members of Trump's transition team for a series of role-playing scenarios designed to establish a "whole of government" response to potential medical crises. The exercises addressed a range of policies including travel bans, equipment shortages and procurement, and vaccines, based on a National Security Council guidebook prepared in 2016 designed to assist leaders "in coordinating a complex U.S. Government response to a high-consequence emerging disease threat anywhere in the world (KHN, 2020a). Following recommendations of the Obama administration Tom Bossert, the homeland security advisor "had called for a comprehensive biodefense strategy against pandemics and biological attacks" (Dozier and Bergengruen, 2020).

Yet, throughout its first three years the Trump administration not only failed to follow its recommendations for responding to pandemics, but actively dismantled key parts of the infrastructure. In May 2018 NSC Advisor John Bolton disbanded the NSC team. Timothy Ziemer, a top White House official in the NSC for leading the U.S. response against a pandemic, left the Trump administration (KHN, 2020a). By January 2021 only 8 of the 30 participants remained in the government, amid a large-scale exodus of scientific personnel (Toosi, 2020).

The Trump administration carried out significant cutbacks to the top federal health authority, the CDC (18%) and also reduced the budget of the National Institute of Health (NIH). Since 2010 the CDC experienced a 10% budget decrease and in 2017 a hiring freeze resulting in 700 vacant positions. By 2019 almost half of all scientific leadership positions in federal agencies were left vacant (Tenpas, 2020). Absent NSC direction, Health and Human Services Secretary Alex Azar, a former pharmaceutical company executive, was placed in overall charge of what would become a highly politicized effort to manage public relations in order to maintain economic growth in an election year.

China's initial lack of transparency contributed to the ineffective U.S. (and global) response. Officials rebuffed United States offers to provide assistance from CDC scientists or to obtain a sample of the virus. Until

global population and led to 284,000 deaths globally, with 60.8 million U.S. cases and 12,469 deaths. Ebola (2014–2016) resulted in 28,652 cases and 11,325 deaths globally and just 1 U.S. death (Ries, 2020).

Wuhan was shut down on January 18 Chinese authorities insisted that there was "no clear evidence of human-to-human transmission" (Associated Press, 2020).[4] However, the most pressing immediate problems were domestic: passivity based on narrow political calculation and politicization. The ensuing two months following confirmation of the deadly virus saw the administration openly in denial and largely inactive. Although the CDC issued a public alert on January 8 and began monitoring flights from China to Los Angeles, San Francisco, and New York preparation was sporadic, de-centralized, and carried out largely by mid-level administrators. The CDC in any case has limited authority and cannot impose policies on states (Commonwealth Fund, 2021). Health and Human Services (HHS) Director Alex Azar sought to have the NSC exert ultimate control, but the president and his leading advisors were preoccupied by his impeachment trial and concerned about the effect of the disease on the economy. The president dismissed the seriousness of the disease and proclaimed that the virus would "miraculously go away" even as he privately acknowledged its dangers (Gangel et al., 2020). In mid-January contingency plans were drawn up by HHS to implement the Defense Production Act, enabling the government to compel private companies to produce goods and services deemed essential to national security. However, no steps were taken until March. Finally, on January 29 the NSC did acquire control of the response, and the Coronavirus Task Force was established under the direction of Vice-President Pence. Two days later a public health emergency was declared. However, throughout February the focus was almost exclusively on travel from China and the evacuation of U.S. citizens rather than on testing or medical supplies. On

[4] At the outset the Trump administration praised China for its rapid response and transparency. However, as the pandemic reached full force Trump began to scapegoat China, repeatedly referring to the "China virus" and "Kung Flu." Members of his administration but also independent journalists proposed that the virus emerged not from zoonotic transmission but rather as a result of a "lab leak" at the Wuhan Institute of Virology (WIV) resulting from irresponsible "gain of function" research in which U.S. scientists were also participants. The WHO, most U.S. and international media, and the scientific community initially rejected these claims. However, the claims were re-introduced in March, 2021 in the U.S. media and the Biden administration appointed an investigative task force to assess their validity, with inconclusive results. Although there is no indisputable evidence for the "lab leak" hypothesis there is increasing circumstantial evidence suggesting the need for a comprehensive and investigation. For a balanced account see Maxmen and Malapaty (2021) and Harrison and Sachs (2022). https://www.pnas.org/doi/10.1073/pnas.2202769119#sec-2.

January 31 all non-U.S. citizens were barred from entering the United States from China. However, 300,000 people had entered the United States from China in the previous month.

Testing and Procurement

The administration's passivity was expressed most clearly and tragically in two crucial policy areas. The first and perhaps most serious was the delay in developing an effective diagnostic test that would allow federal agencies, state, and local governments to map the development of the virus and contain it through quarantines and lockdowns. What Nina Burleigh (2021) called "the original sin of the pandemic…more costly than any other failing" derived only in small part from China's delays in sharing e samples of the virus. Following China's publication of the genome online on January 11 many countries, including China and Germany developed diagnostic tests, with the latter adopted by the W.H.O. at the beginning of February. However, reflecting its "America First" nationalism and antipathy toward international organizations the White House rejected the W.H.O.'s offer to provide tests, instead tasking the CDC to develop its own test, thereby excluding universities, private labs, and world health organizations from the effort. Not until early February did the CDC develop its own test. However, this contained a small mistake which delayed their use for a further six weeks. The lack of testing made it impossible to determine the scope of the disease. It also kept the number of infections artificially low. At an open-air and mask-free rally in March in Oklahoma Trump proclaimed that he had ordered his staff "to slow the testing down" (Burleigh, p. 51). However, by March, the pandemic had reached full force, especially in New York, Seattle, and, more generally, within populous Democratic-led states. On March 11 New York City was forced to close its schools, moving refrigerator trucks to load corpses from hospitals while workers dug mass graves on Bronx's Hart Island.

The absence of testing led to dramatic underestimations of the spread of the disease, especially among people who were asymptomatic. Recent NIH data indicate approximately 17 million undiagnosed Covid-19 cases in the early months. For every diagnosed Covid-19 case there were 4.8 undiagnosed cases (Kalish et al., 2021). Thus, the inability to provide adequate testing not only contributed to the spread of the disease but also has implications for understanding the pandemic and preparing for new ones.

The lack of preparedness was exhibited not only in the problems with testing, but also shortages of medical equipment, including personal protective equipment (PPE). The nation's emergency stockpile was gradually depleted as a result of lack of funding. The strict lockdown in China disrupted supply chains that had become vital due to outsourcing. The United States imports 48% of PPE including 70% of face masks (Brown, 2020). However, at the outset the White House argued against further appropriations on the bases of both budgetary concerns and the desire to avoid alarming the country. In the end, after extensive infighting Congress approved an $8 billion supplemental package that was signed into law on March 8. At this point, however, supplies were further depleted and costs soared. In April both China and Russia sent planeloads of medical equipment to the United States.

Donald Trump's son-in-law, Jared Kushner, was placed in charge of procurement through the White House Covid-19 Supply Chain Task Force, largely staffed by inexperienced personal friends operating on a voluntary basis. In accordance with the Trump administration's neoliberal philosophy private companies were prioritized over states and the federal government and authorized to charge market rates, with no cost control, resulting in excessive profits but diminished supplies. Memoranda of agreement showed that "suppliers had complete discretion about how to distribute supplies across hotspot counties…nothing in the MOAs appears to prevent a supplier from sending all of its supplies designated for hotspots to just a single customer in one of the hotspots" (Burleigh, p. 44). The ultimate result was the disengagement of the federal government, leaving problems to mostly Democratic Covid-afflicted states. On March 16 as the nation shut down President Trump informed governors on a conference call that "We're backing you 100%…although respirators, ventilators, all the equipment—try getting it yourselves." (Burleigh, p. 47).

Lockdowns

Problems of testing and procurement reflected in important respects the aforementioned distinctive hostility to the state in American right-wing populism. The Trump administration's resistance to lockdowns—at times referencing "herd immunity" with "deadly consequences" (KHN, 2020b; House Select Subcommittee, 2020a)—was further encouraged by the consequences of lockdowns for workers, especially in the service and retail

sectors, many of whom received only limited support through supplemental unemployment insurance and the "paycheck protection" program. Although five days after the WHO declared a global pandemic the Trump administration recommended that citizens restrict travel, there was no advisory concerning lockdowns, which were more difficult to justify given the lack of information resulting from the aforementioned lack of testing capacity. Decisions were left to individual states and cities. Thus New York City shut down schools on March 15 but waited another week for a comprehensive lockdown, with devastating results. California imposed a lockdown on March 22 while Georgia waited until April 3.

The resistance to lockdowns has been a defining feature of right-wing populism and had especially strong political overtones in the United States. President Trump denounced them, repeatedly staging mass rallies in which social distancing and masks were not required, leading to surges in the host counties (Nayer, 2020). Between June 20 and September 22, 2020 Trump held 18 campaign rallies, leading to an estimated 30,000 excess Covid cases and 700 deaths (Bernheim et al., 2020). Referring to Michigan, the state with the fourth highest number of deaths due to Covid, he complained that the state's lockdown measures were "too tough." As an armed gang advanced on the state capitol he called on supporters to "Liberate Michigan."

While there is controversy over the efficacy of lockdowns and their collateral social and cultural impacts, the great majority of studies indicate that lockdowns as well as other social distancing measures play a significant role in reducing the spread of the disease (Megarbane et al., 2021; Chen et al., 2020; Togoh, 2020). Moreover, lockdowns played a very minor role in the economic slump. People began withdrawing from the economy—and to some extent from the workforce—before stay-at-home orders; lockdowns simply provided the legal basis for them to do so voluntarily (Goolsbee and Syversen, 2020). School closings certainly impacted children (and parents) and contributed to mental health problems.

The resistance to lockdowns, masks, and other forms of social distancing illustrates the extent to which health policy and, more generally, science became politicized within a context of growing polarization, confirmed by numerous studies indicating a deepening partisan gap in public attitudes (Schaeffer, 2021). Republicans consistently underestimated the severity of the pandemic and the risks associated with various practices while Democrats did the reverse (Rothwell and Desai, 2020). Likely Clinton voters, for example, were more than twice as likely to